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GAMMIS Batch Professional Health Care Claim 837P Companion Guide 004010 X098A1

Georgia Medicaid Management Information System
Fiscal Agent Services Project

Version 1.4

Disclaimer: The information contained in this Companion Guide is subject to change. EDI submitters are advised to check the Provider Pre-Readiness site http://providerinfo.mmis.georgia.gov/providerprereadiness/home.aspx) regularly for the latest updates before and after go-live.

Document Control

Modification Log

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0.2	12/17/2009	Kim White	Updates to questions documented throughout entire document.
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1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the *Final Rule for Standards for Electronic Transactions* can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The *HIPAA Implementation Guides* can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

1.1 Purpose

The 837 Professional transaction is used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic Professional claim submissions to the Georgia Department of Community Health (DCH). The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections, and reversals. This transaction will support the submission of Professional claims and Professional encounters.

The 837 Professional transaction is the electronic correspondent to the paper CMS-1500 claim form; therefore, any claim types or encounter data submitted on the CMS-1500 form correlate to the 837 Professional transaction, if data is submitted electronically.

All required segments within the 837 Professional transaction must always be sent by the submitter and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments contained within the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transaction such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

HP Enterprise Services and DCH have indicated at a “quick glance” items that have changed between the current fiscal agent and the new fiscal. Those items are highlight for easy identification.

1.2 Special Considerations for 837 Professional Transaction

1. **Subscriber, Insured = Member in the Georgia Medicaid Eligibility Verification System**

The Georgia Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/recipients are primary subscribers within each.

2. **Provider Identification = Georgia Medicaid ID or NPI**

The implementation date for National Provider Identifier (NPI) was May 23, 2007.

Beginning May 23, 2008 for all health care providers, the Provider NPI, Taxonomy Code and ZIP Code + 4 postal code must be received in the appropriate loops. The NPI will be sent in the NM109, where NM108 equals XX. The Taxonomy Code will be sent in the PRV03 and the Zip Code + 4 postal code will be sent in the N403 and N404.

For all non-healthcare providers where an NPI is not assigned, the claim must contain the Medicaid Provider Number within the appropriate loops within the REF segment where REF01 equals 1D.

3. **Logical File Structure:**

There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE) however; the functional groups must be the same type.

4. **Submitter:**

Submissions by non-approved trading partners will be rejected.

5. **Acknowledgement Transaction (824 Application Reporting)**

A response transaction will be returned to the trading partner that is present within the ISA06 data element.

The Georgia Department of Community Health will provide an 824 Application Reporting Acknowledgment for all transactions that are received.

You will receive this acknowledgment within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the transaction submitted was a claim transaction, i.e. 837, you will receive either the 835 or the unsolicited 277.

Note: The 835 and unsolicited 277 are only provided weekly.

6. **When NM108 = 24 or REF01=EI:**

If the NM108 equals 24 (Employer Identification Number (EIN)) or the REF01 equals EI (EIN) within any loop, the value in the corresponding NM109 or REF02 must be in the format of XX-XXXXXXX.

Note: This format includes the hyphen (-).

7. Claims Allowed per Transaction (ST/SE envelope):

The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.

The Georgia Department of Community Health does not have a maximum for the number of claims per transaction (ST/SE envelope), however the file size must not exceed 50mb.

8. Document Level:

The Georgia Department of Community Health processes files at the claim level. It is possible based on where the error(s) occur within the hierarchical structure that some claims may pass compliance and others will fail compliance. Those claims that pass compliance will be processed within the Medicaid Management Information System (MMIS). Those claims that fail compliance will be reported on the 824.

9. Dependent Loop:

The Georgia Department of Community Health, the subscriber is always the same as the patient (dependent). Claims containing data in the Patient Hierarchical Level (2000C loop) may not process correctly.

10. Compliance Checking:

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In addition to Level 4, Level 7 patient (dependent) level will occur if 2000C patient loop is received. All other levels will be validated within the GAMMIS.

11. Identification of TPL

For each claim at the header level, if loop 2320 (Other Subscriber Information) is present and SBR09 (Claim Filing Indicator) is not equal to MB (Medicare), 16 (HMO Medicare Risk), HM (HMO) or MC (Medicaid), the COB Payer Paid Amounts (AMT01=D) received in the 2320 loop(s) will be summed together for the Payer Paid Amount.

Note: The 2320 loop can repeat multiple times per claim

12. National Drug Code (NDC)

The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. In Order for the Georgia Department of Community Health to fully realize the drug rebate savings for claims billed, an NDC Code for the billed drug is required effective 01-01-2007.

2 Transmission and Data Retrieval Methods

HP Enterprise Services supports several types of data transport depending upon the provider's, trading partner's or billing agent's needs. Providers and their representatives submit and receive data using: Web Portal, Provider Electronic Solutions (PES) software, Remote Access Server (RAS), diskette/CD-ROM/tape, DVD, Secure File Transfer Protocol (SFTP) and/or Value Added Networks (VANs) for interactive transactions.

1. Web portal: Data is transmitted using the secure Web Portal. The Web Portal is normally available to customers 24 hours per day, seven days per week with the exception of scheduled maintenance. Submission options are Direct Data Entry (DDE) and Batch. The GAMMIS Web Portal (as a single gateway) is an important tool providing general and program specific information and links to other programs, applications, related agencies, and resources. The Web Portal has both secure (intranet) and non-secure (public internet) areas.

2. HP Enterprise Services provides free software called Provider Electronic Solutions (PES) for the submission of claim transactions. The system PC minimum requirements for PES are Windows 2000 or higher. This software complies with HIPAA requirements and is available to all providers who wish to submit claims electronically. The HIPAA-ready forms available for billing Georgia Medicaid using PES include:

    a. 837 Professional

    b. 837 Institutional (Inpatient, Outpatient and LTC)

    c. 837 Dental

    Georgia Medicaid providers can download a copy of the PES software from the Web Portal, have it sent using e-mail, or request a copy from the EDI Services to receive a CD through the United States Postal Service (USPS). A user manual, installation guide, and the initial password to access the PES application comes with the software. The EDI Services team will assist and answer any immediate questions or refer providers needing additional training to the Provider Relations team.

    Note: For additional information regarding specific PES procedures and functionality, please locate the PES Manuals located on our website at www.mmis.georgia.gov. Each transaction has its own PES manual on the website, for the following services: Professional Claims (CMS-1500) Billing, Dental, and Inpatient, Outpatient and LTC Institutional (UB-04) claims.

3. Remote Access Server (RAS): The RAS enables providers to access all options of the secure Web portal without the use of an Internet Service Provider. This option is available to users who do not have an existing Internet connection. The RAS server typically supports users that need a dial-up option. Trading partner data transmitted using the RAS can be transmitted the same as the Internet secure site using DDE or upload batch transactions.

After the connection is established, the landing page is presented. A user either logs on and is presented with their secure provider page, or selects 'register' if they are a first-time user.

Once logged on, the user will have access to the various secure Web portal options, including File Upload and File Download for EDI transactions.

4. Diskette/CD-Rom/DVD/Tape: Providers experiencing technical connection issues can mail a labeled copy of the EDI claims file downloaded on a CD-ROM, tape, or diskette. HP Enterprise Services does not anticipate that most providers will typically need to submit EDI transactions using diskette/CD-ROM/DVD/tape.

   Note: This option is reserved for special instances where the provider is having critical internet connection issues preventing them from accessing the Web Portal or server. The CD-ROM/diskette must be labeled to identify the trading partner and instructions on where to locate the EDI file for upload or it will be returned as unprocessed to the provider. Providers are responsible for correcting any connection issues to resume transmitting claims using the normal transmission methods (Web Portal, RAS, PES, or VANs).

5. Secure File Transfer Protocol (SFTP): SFTP uses Secure Shell (SSH) to encrypt and then securely transmit data across a potentially unsecured connection. Functionally SFTP (required) is similar to FTP, but offers protection to sensitive data. Secure Shell or SSH is a network protocol that allows data to be exchanged using a secure channel between two networked devices.

   This option allows provider, vendors, and all other trading partners to transfer claim files to HP Enterprise Services using the secure file transfer protocol server. Trading partners must notify us specifically if wishing to use this transmission method to transmit files.

   HP Enterprise Services requires that the SFTP submitters send their public key and HP Enterprise Services exchanges its public key with the submitter for encryption purposes. HP Enterprise Services will setup a username and password for the submitter to access the server.

6. Value Added Networks (VANs): VANs support interactive transactions for established vendors. VANs sign contracts with the State and set up unique VAN-specific communication arrangements with HP Enterprise Services.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: www.mmis.georgia.gov.

2.1 File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI will allow upload and download of zipped or compressed files.

EDI requires file extensions. Preferred extension is .dat, however other extensions such as .txt, .edi, .txn are allowed.

Note: Only one X12 transaction file is permitted in each "zipped" file. Any file size that is 5MB or larger is required to be zipped or compressed.

The Web portal is designed, but not limited to support the following Internet browsers:

1. Internet Explorer, version 6 or later
2. Firefox, version 1.5 or later

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3 Testing

In order to submit claims, a provider or their representative or billing agent must be authorized. The authorization process requires the submission of the Electronic Data Interchange Agreement, issuance of a trading partner ID, and testing to assure the trading partner can accurately submit transactions.

The trading partner certifies their transactions through EDIFECS Ramp Manager. The Ramp Manager product is a free self-service, Web-based testing tool for X12 transactions. It includes a number of support utilities for submitting, troubleshooting, and testing X12 files. The intent is to certify that an entity can successfully submit a compliant X12 file.

More information about testing procedures is located on the Provider Public Web site at: www.mmis.georgia.gov.

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4 Transmission Responses

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Application Reporting transaction (824), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a 'front end' compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the 'front end' compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive an Application Reporting Transaction (824) to provide feedback on the transaction. The 824 contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 824 response will be generated and the transaction is passed on for processing.

Once the transaction is accepted the transaction is translated and processed. If the file contains an invalid Billing Provider, an X12 version 3070 – 277U will be generated.

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5 EDI Support

The EDS EDI Unit is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software
3. Provide assistance to Billing Agents, Clearinghouses and Software Vendors
4. Identifying and troubleshooting technical issues
5. Data Exchange help

The EDI staff will be available Monday through Friday 8:00 a.m. to 5:00 p.m. EST by calling 877-261-8785 or 770-325-9590.

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6 Control Segment Definitions for Georgia Medicaid 837 Professional Transaction

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer
TA1 – Interchange Acknowledgement

6.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
B.3	N/A	ISA	ISA02 - Authorization Information	[space fill]
B.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
B.4	N/A	ISA	ISA04 - Security Information	[space fill]
B.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.4	N/A	ISA	ISA06 - Interchange Sender ID	'Trading Partner ID' Supplied by Georgia Medicaid left justified and space filled.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				The Trading Partner ID, will be the same Trading Partner ID used in current system.
B.4	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.5	N/A	ISA	ISA08 - Interchange Receiver ID	'**77034**' – GA MMIS Trading Partner ID. Left justified and space filled. **Note:** Current system this value was 100000.
B.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD
B.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM
B.5	N/A	ISA	ISA11 - Interchange Control Standards Identifier	'U' – Interchange Control Standards Identifier
B.5	N/A	ISA	ISA12 - Interchange Control Version Number	'00401' – Control Version Number
B.5	N/A	ISA	ISA13 - Sequential Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02
B.6	N/A	ISA	ISA14 - Acknowledgment Request	'0' – No Acknowledgement Requested '1' – Acknowledgement Requested – HP Enterprise Services will return an 824 Application Reporting transaction.
B.6	N/A	ISA	ISA15 - Usage Indicator	'T' - Test Data 'P' - Production Data
B.6	N/A	ISA	ISA16 - Component Element Separator	':' – Component Element Separator

6.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.7	N/A	IEA	IEA01 - Number of included Functional Groups	Number of included Functional Groups
B.7	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13

6.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.8	N/A	GS	GS01 -Functional ID Code	'HC' – Health Care Claim (837)
B.8	N/A	GS	GS02 - Application Sender's Code	This will be equal to the value in ISA06.
B.8	N/A	GS	GS03 - Application Receiver's Code	This will be equal to the value in ISA08.
B.8	N/A	GS	GS04 - Date	The date format is CCYYMMDD
B.8	N/A	GS	GS05 – Time	The time format is HHMM

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.9	N/A	GS	GS06 - Group Control Number	Group Control Number
B.9	N/A	GS	GS07 - Responsible Agency Code	'X' – Responsible Agency Code
B.9	N/A	GS	GS08 Version/Release/ Industry ID Code	'004010X098A1' – Version / Release / Industry Identifier Code

6.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.10	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
B.10	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06

6.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
62	N/A	ST	ST01 – Transaction Set Identifier Code	'837' – Health Care Claim

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
62	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number

6.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
572	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set Including ST and SE.
572	N/A	SE	SE02 – Transaction Set Control Number	Must be identical to the value in ST02

6.7 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.11	N/A	TA1	TA101 - Interchange Control Number	Interchange control number of the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA102 - Interchange Date	The date format is YYMMDD Date within the original interchange received (ISA/IEA)

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.11	N/A	TA1	TA103 - Interchange Time	The time format is HHMM Time within the original interchange received (ISA/IEA)
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	'A' – Transmitted interchange control structure header/trailer received without errors. 'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted. 'R' – Transmitted interchange control structure header/trailer rejected due to errors.
B.12	N/A	TA1	TA105 - Interchange Note Code	See Implementation Guide for valid values

6.8 Valid Delimiters

The following delimiters must be used for the 837P for Georgia Medicaid otherwise the transaction may not process correctly.

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

7 Companion Guide for the 837P Transaction

This section specifies X12 837P fields for which Georgia Medicaid has specific requirements.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Header				
64	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
65	N/A	BHT	BHT06 - Transaction Type Code	'CH' – Chargeable (Use with Professional Health Care Claim)
Submitter Name				
69	1000A	NM1	NM109 - Identification Code	'GEORGIA EDI Trading Partner ID'
Receiver Name				
75	1000B	NM1	NM103 – Name Last or Organization Name	'GEORGIA HEALTH PARTNERSHIP'
75	1000B	NM1	NM109 - Identification Code	'77034' - GEORGIA Medicaid Payer ID
Billing Provider Name				
79	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider
80	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
80	2000A	PRV	PRV03 - Provider Specialty Code	'Provider Taxonomy Code'
86	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				'24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
86	2010AA	NM1	NM109 - Identification Code	If, NM108=XX (NPI ID) If, NM108=24 (EIN) If, NM108=34 (SSN)
89	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks)
2010AA Billing Provider REF Segment After May 23, 2008, REF01=1D, where REF02=Medicaid Provider Number should only be sent if the billing provider is not required to have a National Provider Identifier.				
92	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01=1D should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-Healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'
92	2010AA	REF	REF02 - Reference Identification	If, REF01=EI (EIN) If, REF01=SY (SSN)

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				If, REF01=1D (Georgia Medicaid Provider ID) See comments on associated REF01
Subscriber Level For Georgia Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.				
109	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
110	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	Refer to 837P Implementation Guide for Valid Values
112	2000B	SBR	SBR09 - Claim Filing Indicator Code	'MC' - Medicaid
Subscriber Name				
118	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
119	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
119	2010BA	NM1	NM109 - Identification Code	'GEORGIA Member Medicaid Number'
Payer Name				
131	2010BB	NM1	NM103 - Name Last or Organization Name	'GEORGIA HEALTH PARTNERSHIP'
131	2010BB	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
131	2010BB	NM1	NM109 - Identification Code	'77034' - GEORGIA Medicaid Payer ID

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Claim Information				
171	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Account Number Value received will be returned on the '835' Remittance Advice
173	2300	CLM	CLM05-1 - Facility Type Code	Enter the 2-digit Place of Service (POS) code at the claim header. *Note if the POS is not received at the detail, the header POS will be copied to the detail for processing.
173	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value indicates whether the current claim is an original claim, a void, or an adjustment. Valid values are as follows: 1 = Original Claim 7 = Adjustment (Replacement of Paid Claim) 8 = Void (Credit only). The ICN to Credit should be placed in the REF02, where REF01=F8. Providers must use the most recently paid ICN when voiding or adjusting a claim.
176-177	2300	CLM	CLM11-1, 11-2, 11-3: Related Causes Code	If the services being rendered are the result of an injury or accident, enter one of the standard two-

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				character injury codes listed below in each Data Element if they apply. Otherwise, this field may be left blank. AA = Auto Accident EM = Employment OA = Other Accident
230	2300	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
230	2300	REF	REF02 - Reference Identification	Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided).
EPSDT Referral				
October 2002 Addenda 37	2300	CRC	CRC01 – Code Category	'ZZ' – Mutually Defined Enter this for Health Check Referral Information.
October 2002 Addenda 38	2300	CRC	CRC02 – Certification Condition Indicator	'Y' – Yes 'N' – No For Child Health Check-Up screenings enter a 'Y' if the patient is referred to another provider as a result of the screening. Enter 'N' if no referral is made. If 'N' is entered here, enter 'NU' in 2300, CRC03

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
October 2002 Addenda 38	2300	CRC	CRC03 – Condition Code	Enter one of the following valid values. For Child Health Check-Up Exam Result: 'AV' – Patient Refused Referral 'NU' – Not Used (Patient Not Referred) 'S2' – Under Treatment 'ST' – New Services Requested
Referring Provider Name				
283	2310A	NM1	NM101 – Identify Identifier Code	Enter 'DN' (Referring Provider)
284	2310A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
284	2310A	NM1	NM109 - Identification Code	If, NM108=XX (NPI ID) If, NM108=24 (EIN) If, NM108=34 (SSN)
286	2310A	PRV	PRV03 - Provider Specialty Code	'Referring Provider Taxonomy Code' Used for claims submitted with NPI ID

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
288	2310A	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Non-Healthcare providers must send this REF segment where REF01='1D'
289	2310A	REF	REF02 - Reference Identification	If, REF01=1D (GEORGIA Medicaid Provider ID)
Rendering Provider Name				
292	2310B	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
292	2310B	NM1	NM109 - Identification Code	If, NM108=XX (NPI ID) If, NM108=24 (EIN) If, NM108=34 (SSN)
293	2310B	PRV	PRV03 - Reference Identification	'Rendering Provider Taxonomy Code' Used for claims submitted with NPI ID
296	2310B	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Non-Healthcare providers must send this REF segment where REF01='1D'

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
296	2310B	REF	REF02 - Reference Identification	If, REF01=1D (GEORGIA Medicaid Provider ID)
Other Subscriber Information				
327-330	2320	CAS	CAS02, CAS05, CAS08, CAS 11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
332	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
332	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL)
334	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
334	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Allowed Amount Paid
Other Payer Name				
361	2330B	NM1	NM109 – Identification Code	This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer if the 2430 loop is present. Georgia Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. **Note:** The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				detail.
366	2330B	DTP	DTP01 - Date Claim Paid	'573' - Other Payer Adjudication Date
366	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
367	2330B	DTP	DTP03 – Date Time Period	TPL Adjudication Date (CCYYMMDD)
Service Line				
399	2400	LX	LX01 – Line Counter	Georgia Medicaid will accept up to the HIPAA allowed 50 detail lines per claim.
401	2400	SV1	SV101-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
401	2400	SV1	SV101-2 – Procedure Code	Enter the procedure code for this service line.
403	2400	SV1	SV104 – Service Unit Count	Enter the Service Unit Count. Submit whole numbers only.
406	2400	SV1	SV109 – Emergency Indicator	Enter 'Y' if the services are known to be an emergency.
406	2400	SV1	SV111 - EPSDT Indicator	Enter 'Y' when the member was referred for services as the result of a Child Health Check-up screening.

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
406	2400	SV1	SV112 – Family Planning Indicator	Enter 'Y' if the services relate to pregnancy or if the services were for Family Planning.
Detail Line Rendering Provider Name Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is different than the Billing Provider (2010AA).				
503	2420A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
503	2420A	NM1	NM109 - Identification Code	If, NM108=XX (NPI ID) If, NM108=24 (EIN) If, NM108=34 (SSN)
505	2420A	PRV	PRV03 - Reference Identification	'Detail Level Rendering Provider Taxonomy Code' Used for claims submitted with NPI ID
507	2420A	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Non-Healthcare providers must send this REF segment where REF01='1D'

837 Professional Health Care Claim				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
508	2420A	REF	REF02 - Reference Identification	If, REF01=1D (Georgia Medicaid Provider ID)
Line Adjudication Information				
555	2430	SVD	SVD01 – Identification Code	This number should match one occurrence of the 2330B-NM109 identifying Other Payer
IG 555 October 20002 Addenda 80	2430	SVD	SVD02 – Service Line Paid Amount	Enter the Third Party Payment Amount (TPL) at the line item level only. This will also be used for Crossover detail paid amount.
Line Adjustment				
560-565	2430	CAS	CAS02, CAS05, CAS08, CAS 11, CAS14, CAS17 – Adjustment Reason Code	'1' – Deductible '2' – Coinsurance Other external code source values from code source 139 are allowed.
560-565	2430	CAS	CAS03, CAS06, CAS09, CAS 12, CAS15, CAS18 – Adjustment Amount	If Adjustment Group Code (CAS01)=PR and Adjustment Reason Code value is: '1', enter the Medicare Deductible Amount ' 2', enter the Medicare Coinsurance Amount

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8 External Code Source List

Below is a list of external code source list links:

Place of Service (POS):

http://www.cms.hhs.gov/PlaceofServiceCodes/03_POSDatabase.asp#TopOfPage

Adjustment Reason Codes (External Code Source 139):

http://www.wpc-edi.com/content/view/695/1

Patient Status Code:

Please refer to the Policy Manual located – www.xxx.com

Note: Additional external code sources references can be found in Section C of the 837D Implementation Guide.

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